LASA Error – Colchicine/Cyclizine

RECORD

- A patient was prescribed Cyclizine 50mg Tablets (84), three times a day, a regular repeat prescription for anti sickness.
- During assembly of the prescription, Colchicine 0.5mg Tablets (84) were selected in error and this was not noted by both dispenser and the responsible pharmacist.
- The patient took Colchicine three times a day across one calendar month before a family member noted the error and they were rushed to A&E for assessment.
- The patient was elderly, experienced lethargy, falls, sickness and skin discolouration.
- During a two week hospital admission they were treated for multiple infections (UTI and respiratory). Sadly the patient did not recover and passed away in hospital.
- At the time of sharing this case it is unknown if the dispensing error has been determined as the cause of death by a coroner.

LEARN

- This case highlights that LASA errors remain a significant risk in the dispensing process.
- Whilst the PQS highlighted the most common LASA errors, there are many more that have been reported since.
- Potential to consider focusing learnings on medications with most serious consequences when prescribed in error - for example, DOACs and Colchicine.

SHARE

- Details were shared with MSOs at the CPPSG meeting for consideration across the wider pharmacy profession.

ACT

- Dispensary Layout: There was no clear segregation between the medicines in drawers and both packs were black/white in appearance. LASA stickers were used elsewhere but not near these medicines.
- Colchicine has been segregated in a red basket with ‘Take Care’ warnings to mitigate picking errors in addition to encouraging patient counselling given the risk of toxicity when taken incorrectly without a break.
- Training: Additional training on LASA errors was shared with the full dispensary team to encourage reflection on how they read and interpret drug names on prescriptions. and during assembly. The CPPSG training on LASA errors has also been shared with all our pharmacies with the addition of a page on Colchicine.
- Companywide SOP change on the storage of Colchicine plus counselling patients.
- Consideration of PMR systems that have the ability to use barcode accuracy checks.

REVIEW

- Near miss logs and monthly safety reports were all up to date at the pharmacy. LASA errors had not been noted as a regular issue for an experienced team.
- CPPSG members to consider and review within their organisations